Version 7/03

APPLICATION FOR FEDERAL ASSISTANCE

1. TYPE OF SUBMISSION:

Application	Preapplication
☐ Construction	☐ Construction
☒ Non-Construction	☐ Non-Construction

2. DATE SUBMITTED: 1/03/06	Applicant Identifier:
3. DATE RECEIVED BY STATE:	State Application Identifier: Not applicable
4. DATE RECEIVED BY FEDERAL AGENCY:	Federal Identifier:

5. APPLICANT INFORMATION

Legal Name: Washington State Department of Health	Organizational Unit: Department: Infectious Disease and Reproductive Health
Organizational DUNS: 808883128	Division: Community and Family Health
Address: Street: P O Box 47841	Name and telephone number of the person to be contacted on matters involving this application *(give area code)*
City: Olympia	Prefix: Mr. / First Name: Darren
County: Thurston	Middle Name: Scott
State: Washington / ZIP: 98504-7841	Last Name: Layman
Country: United States	Suffix:
6. EMPLOYER IDENTIFICATION NUMBER *(EIN)*: 9 1 - 1 4 4 4 6 0 3	Phone Number *(give area code)*: (360) 236-3437 / FAX Number *(give area code)*: (360) 664-2216

8. TYPE OF APPLICATION: ☐ New ☒ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es): (See back of form for description of letters) ☐ ☐

Other *(specify)*:

7. TYPE OF APPLICANT: *(See back of form for Application Types)*: State

Other *(Specify)*:

9. NAME OF FEDERAL AGENCY: DHHS, HRSA, HIV/AIDS Bureau, Division of Service Systems

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 9 3 - 9 1 7

TITLE: *(Name of Program)*: HIV CARE Grant Program

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Ryan White CARE Title II

12. AREAS AFFECTED BY PROJECT *(cities, counties, states, etc.)*: Washington State

13. PROPOSED PROJECT:

Start Date	Ending Date
4/1/06	3/31/07

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant	b. Project
9th Congressional District	1st, 2nd, 3rd, 4th, 5th, 6th, 7th 8th, 9th

15. ESTIMATED FUNDING:

a. Federal	$ 11,198,763
b. Applicant	$
c. State	$ 5,599,382
d. Local	$
e. Other	$
f. Program Income	$
g. TOTAL	$ 16,798,145

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. ☐ YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:

DATE

b. ☒ NO. PROGRAM IS NOT COVERED BY E.O. 12372 OR PROGRAM HAS NOT BEEN SELECTED STATE FOR REVIEW

17. IS APPLICATION DELINQUENT ON ANY FEDERAL DEBT?

☐ YES If "Yes," attach an explanation. ☒ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix	First Name	Middle Name
Ms.	Patty	L.
Last Name: Hayes		Suffix: RN, MN
b. Title: Assistant Secretary, Community and Family Health		c. Telephone Number *(give area code)*: (360) 236-3723
d. Signature of Authorized Representative: Patty Hayes		e. Date Signed: 1/03/06

ii. Table of Contents

ix. Program Narrative

FY 2006 AIDS Drug Assistance Program (ADAP) Application

iii. Application Checklist

OMB Approval No. 0920-0428

CHECKLIST

Public Burden Statement: Public reporting burden of this collection of information is estimated to average 4 - 50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application: ☐ NEW ☒ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

	Included	NOT Applicable
1. Proper Signature and Date for Item 18 on SF 424 (FACE PAGE)	☒	
2. Proper Signature and Date on PHS-5161-1 "Certifications" page.	☒	
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	☒	
4. If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		
☐ Civil Rights Assurance (45 CFR 80)		
☐ Assurance Concerning the Handicapped (45 CFR 84)		
☐ Assurance Concerning Sex Discrimination (45 CFR 86)		
☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)		
5. Human Subjects Certification, when applicable (45 CFR 46)	☐	☒

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	☒
2. Has the appropriate box been checked for item # 16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☒	
3. Has the entire proposed project period been identified in item # 13 of the FACE PAGE?	☒	
4. Have biographical sketch(es) with job description(s) been attached, when required	☐	☒
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☒	
6. Has the 12 month detailed budget been provided?	☒	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☒	☐
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	☒
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☒

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made.

Name: Lois Speelman
Title: Assistant Secretary, Financial Services
Organization: Washington State Department of Health
Address: P O Box 47901, Olympia, WA 98504-7901
E-mail Address: Lois.Speelman@doh.wa.gov
Telephone Number: (360) 236-4503
Fax Number: (360) 236-4500

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Name: Patty Hayes
Title: Assistant Secretary, Community and Family Health
Organization: Washington State Department of Health
Address: P O Box 47830, Olympia, WA 98504-7830
E-mail Address: Patty.Hayes@doh.wa.gov
Telephone Number: (360) 236-3723
Fax Number: (360) 664-4500

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (If already assigned)

11911444603A1

SOCIAL SECURITY NUMBER

HIGHEST DEGREE EARNED

iv. Budget

BUDGET INFORMATION - Non- Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non- Federal (f)	Total (g)
1. Ryan White Title II	93.917	$	$	$ 11,198,763	$ 5,599,382	$ 16,798,145
2.		$	$	$	$	$ 0.00
3.		$	$	$	$	$ 0.00
4.		$	$	$	$	$ 0.00
5. TOTALS	93.917	$ 0.00	$ 0.00	$ 11,198,763	$ 5,599,382	$ 16,798,145

SECTION B - BUDGET CATEGORIES					
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)Grantee Administration	(2)Planning & Evaluation	(3)Quality Management	(4)ADAP Earmark	
a. Personnel	$ 332,918	$ 112,126	$ 163,246	$ 0	$ 608,290
b. Fringe Benefits	$ 83,230	$ 28,032	$ 40,812	$ 0	$ 152,073
c. Travel	$ 7,842	$ 3,930	$ 6,977	$ 0	$ 18,749
d. Equipment	$ 0	$ 0	$ 0	$ 0	$ 0
e. Supplies	$ 77,094	$ 22,733	$ 26,330	$ 0	$ 126,157
f. Contractual	$ 7,950	$ 117,915	$ 105,000	$ 7,106,359	$ 7,337,224
g. Construction	$ 0	$ 0	$ 0	$ 0	$ 0
h. Other	$ 0	$ 0	$ 0	$ 0	$ 0
i. Total Direct Charges *(sum of 6a -6h)*	$ 509,034	$ 284,736	$ 342,365	$ 7,106,359	$ 8,242,493
j. Indirect Charges	$ 98,817	$ 49,117	$ 62,846	$ 92,383	$ 303,162
k. TOTALS *(sum of 6i and 6j)*	$ 607,850	$ 333,852	$ 405,210	$ 7,198,742	$ 8,545,654

SECTION B - BUDGET CATEGORIES (continued)					
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(5)Consortia	(6)Health Insurance	(7) Minority AIDS Initiative	(8) ADAP from Title II Base	
a. Personnel	$ 0	$ 0	$ 0	$ 0	$ 0
b. Fringe Benefits	$ 0	$ 0	$ 0	$ 0	$ 0
c. Travel	$ 0	$ 0	$ 0	$ 0	$ 0
d. Equipment	$ 0	$ 0	$ 0	$ 0	$ 0
e. Supplies	$ 0	$ 0	$ 0	$ 0	$ 0
f. Contractual	$ 2,424,200	$ 154,902	$ 39,959	$ 0	$ 2,619,061
g. Construction	$ 0	$ 0	$ 0	$ 0	$ 0
h. Other	$ 0	$ 0	$ 0	$ 0	$ 0
i. Total Direct Charges *(sum of 6a -6h)*	$ 2,424,200	$ 154,902	$ 39,959	$ 0	$ 2,619,061
j. Indirect Charges	$ 31,515	$ 2,014	$ 519	$ 0	$ 34,048
k. TOTALS *(sum of 6i and 6j)*	$ 2,455,715	$ 156,916	$ 40,478	$ 0	$ 2,653,109
7. Program Income	$	$	$	$	$ 0.00

v. Budget Justification

1) Grantee Administration		**$607,850**
A. Personnel – TOTAL		**$332,918**
Washington Management Services II - .25 FTE – Vacant	$17,124	
This position is the program manager for HIV Client Services and provides overall supervision to all staff positions and provides oversight for ADAP and Health Insurance Continuation.		
Health Services Consultant 3 - .75 FTE – Barbara Stuart	$41,621	
This position manages the Title II budget, has fiscal responsibilities for ADAP-related contracts and oversees the 340B Rebate Program		
Office Assistant - .2 FTE – Vacant	$4,375	
This position provides program support to the Early Intervention Program.		
Health Services Consultant 4 - .4 FTE – Darren Layman	$24,439	
This position is responsible for the Title II grant, including development of application for Title II funds, programmatic and fiscal reporting, compliance with grant conditions of award, and planning and implementation of consortia-related activities, training, and technical assistance.		
Office Assistant 3 - .6 FTE – Mardene Eldred	$15,495	
This position provides administrative support for HIV Client Services staff including the Early Intervention Program Steering Committee.		
Administrative Assistant 1 - .2 FTE – DeLores Obenland	$6,332	
This position provides support to ADAP by entering client eligibility information into the ADAP database system.		
Secretary Senior - .5 FTE – Sheila Ichita	$19,118	
This position provides lead administrative and clerical support to the HIV Client Services Program Manager and staff.		
Health Services Consultant 3 – 1.0 FTE – Evelyn Linton	$55,494	
This position is responsible for ADAP-related contracts and for coordinating case manager and other trainings.		
Health Services Consultant 1 - .6 FTE – Abby Gilliland	$24,175	
This position is one of three Client Services Representatives and determines client eligibility for the Early Intervention Program.		
Health Services Consultant 2 - .6 FTE – Lori Miller	$28,369	
This position is one of three Client Services Representatives and determines client eligibility for the Early Intervention Program.		
Health Services Consultant 1 - .6 FTE – Ngozi Mbanugo	$21,721	
This position is one of three Client Services Representatives and determines client eligibility for the Early Intervention Program.		
Health Services Consultant 2 - .3 FTE – Robin Vaughn	$14,355	
This position provides trainings to staff and case managers on EIP eligibility-related issues.		
Medical Assistant Specialist 3 - .15 TE – Lorie Wharton	$6,044	
This position coordinates the billing process between the Early Intervention Program and contracted medical and laboratory providers. Prepares drug manufacturer rebate requests, and Medicaid spenddown assistance reports.		
Health Services Consultant 4 - .6 FTE – Teri Hintz	$36,465	
Manages the Early Intervention Program eligibility unit and supervises the Client Services Representatives.		
Health Services Consultant 2 - .4 FTE – Valerie Myer	$17,791	
This position prepares all consortia-related contracts, receives and reconciles related invoices, and assists with other Ryan White-related activities		
B. Fringe Benefits –		**$83,230**
25% of salary		
C. Travel –		**$7,842**
This includes up to four trips to technical assistance meetings in Washington D.C., consortia site visits and technical assistance site visits to other Title II providers and local travel.		
D. Equipment -		**$0**

E. Supplies –		**$77,094**
Supplies include telephone, rent and utilities, campus information and system support, employee training, rent for planning and training meetings, teleconference calls, printing, postage, and computer upgrades.		
F. Contractual –		**$7,950**
Fiscal monitoring of Title II-funded contractors provided by CPA	$4,200	
Consortia/lead agency meeting – This meeting prepares contractors and consortia cochairs for the next contract period.	$3,750	
G. Construction -		**$0**
H. Other -		
I. TOTAL DIRECT CHARGES -		**$509,034**
J. Indirect –		**$98,817**
The indirect charges are based on the DOH cost allocation plan; administration planning at 19.7%, and contracts at 1.3%		
K. TOTAL Grantee Administration		**$607,850**
2) Planning and Evaluation		**$333,852**
A. Personnel – TOTAL		**$112,126**
Washington Management Services II - .25 FTE – Vacant	$17,124	
This position is the program manager for HIV Client Services and provides overall supervision to all staff positions and provides oversight for ADAP and Health Insurance Continuation.		
Health Services Consultant 4 - .2 FTE – Darren Layman	$12,220	
This position is responsible for the Title II grant, including development of application for Title II funds, programmatic and fiscal reporting, compliance with grant conditions of award, and planning and implementation of consortia-related activities, training, and technical assistance.		
Epidemiologist 2 - .15 FTE – Mark Stenger	$9,479	
This position provides oversight to the Title II and ADAP quality management programs and also provides assistance with Title II consortia-related program evaluation and needs assessment activities.		
Health Services Consultant 2 - .35 FTE – Valerie Myer	$15,567	
This position prepares all consortia-related contracts, receives and reconciles related invoices, and assists with other Ryan White-related activities		
Health Services Consultant 3- .6 FTE – Barbara Gimenez	$33,297	
This position conducts data analysis and assessment for the HIV Client Services Early Intervention Program (ADAP). Produces data for program evaluation and planning purposes; tests and evaluations system modification; and develops procedural documentation.		
Health Services Consultant 4 – .4 FTE – Rhonda Bierma	$24,439	
This position supervises claims processing, coordination of benefits and data staff. Oversees the development, maintenance and daily operation of multi-user confidential ADAP data base system.		
B. Fringe Benefits –		**$28,032**
25% of salary		
C. Travel -		**$3,930**
This includes up to four trips to technical assistance meetings in Washington D.C., consortia site visits and technical assistance site visits to other Title II providers and local travel.		
D. Equipment -		**$0**
E. Supplies –		**$22,733**
Supplies include telephone, rent and utilities, campus information and system support, employee training, rent for planning and training meetings, teleconference calls, printing, postage, and computer upgrades.		
F. Contractual –		**$117,915**
Contractual support for the Title IV consortium meetings	$8,165	
Contractual support for statewide workshops such as a CADR training, case management trainings, and consortia-related trainings.	$3,750	

Technical assistance from Public Health – Seattle & King County for consortia-related activities such as needs assessment development and facilitation of the prioritization and allocation process.	$26,000	
Data programming contract for continued maintenance of the EIP client database system	$80,000	
G. Construction -		**$0**
H. Other -		**$0**
I. TOTAL DIRECT CHARGES -		**$284,736**
J. Indirect –		**$49,117**
K. TOTAL Planning and Evaluation		**$333,852**
3) Quality Management		**$405,210**
A. Personnel - TOTAL		**$163,246**
Health Services Consultant 3 - .40 FTE – Barbara Gimenez This position conducts data analysis and assessment for the HIV Client Services Early Intervention Program (ADAP). Produces data for program evaluation and planning purposes; tests and evaluations system modification; and develops procedural documentation.	$22,198	
Medical Assistant Specialist 3- .15 TE – Lorie Wharton This position coordinates the billing process between the Early Intervention Program and contracted medical and laboratory providers. Prepares drug manufacturer rebate requests, and Medicaid spenddown assistance reports.	$6,044	
Health Services Consultant 4 – .6 FTE – Rhonda Bierma This position supervises claims processing, coordination of benefits and data staff. Oversees the development, maintenance and daily operation of multi-user confidential ADAP data base system.	$36,659	
Health Services Consultant 3 - .5 FTE – John Valiant This position provides support with Title II, including ADAP, program evaluation and needs assessment activities.	$23,029	
Information Technology Application Specialist 2- .2 FTE – Jae Taylor This position provides data support to the Title II program by providing data sets for determining unmet need and Title II parity.	$9,373	
Health Services Consultant 4 - .4 FTE – Darren Layman This position is responsible for the Title II grant, including development of application for Title II funds, programmatic and fiscal reporting, compliance with grant conditions of award, and planning and implementation of consortia-related activities, training, quality assurance, and technical assistance.	$24,440	
Epidemiologist 2 - .15 FTE – Mark Stenger This position provides oversight to the Title II and ADAP quality management programs and also provides assistance with Title II consortia-related program evaluation and needs assessment activities.	$9,479	
Health Services Consultant 2 - .5 FTE – Project Position TBD This position will work directly with the Medical Monitoring Project to evaluate Title II-contracted medical providers to assure services are consistent with PHS treatment guidelines.	$20,904	
Health Services Consultant 2 - .25 FTE – Valerie Myer This position prepares all consortia-related contracts, receives and reconciles related invoices, and assists with other Ryan White-related activities	$11,120	
B. Fringe Benefits – 25% of salary		**$40,812**
C. Travel – This includes up to four trips to technical assistance meetings in Washington D.C., consortia site visits and technical assistance site visits to other Title II providers and local travel.		**$6,977**
D. Equipment -		**$0**
E. Supplies – Supplies include telephone, rent and utilities, campus information and system support, employee training, rent for planning and training meetings, teleconference calls,		**$26,330**

printing, postage, and computer upgrades.

F. Contractual –		**$105,000**
Data Programming contractors	$80,000	
HIV Clinical Consultant	$25,000	
G. Construction -		**$0**
H. Other –		**$0**
I. TOTAL DIRECT CHARGES -		**$342,365**
J. Indirect –		**$62,846**
K. TOTAL Quality Management		**$405,210**

4) ADAP Earmark		**$7,198,742**
A. Personnel –		**$0**
B. Fringe Benefits –		**$0**
C. Travel –		**$0**
D. Equipment -		**$0**
E. Supplies –		**$0**
F. Contractual –		**$7,106,359**
Provides funding to the Pharmacy Benefits Manager to implement the Washington State ADAP or Early Intervention Program	$4,447,043	
Provides funding to the Evergreen Health Insurance Program to continue administering the health insurance continuation program.	$2,659,316	
G. Construction -		**$0**
H. Other -		**$0**
I. TOTAL DIRECT CHARGES -		**$7,106,359**
J. Indirect –		**$92,383**
K. TOTAL ADAP Earmark		**$7,198,742**

5) Consortia		**$2,455,715**
A. Personnel –		**$0**
B. Fringe Benefits –		**$0**
C. Travel –		**$0**
D. Equipment -		**$0**
E. Supplies –		**$0**
F. Contractual –		**$2,424,200**
Service funding provided to 14 consortia through contracts with established lead agencies throughout Washington State. Each consortium prioritized services for FY 2006 which can be found in Appendix A, Table 24 of this application. Individual consortium service costs are aggregated for the purposes of this budget and listed by service category in alphabetical order:		
• Ambulatory/Outpatient Medical Care (Primary Medical Care)	$150	
• Buddy/Companion/Chore Services	$10,052	
• Case Management	$1,551,250	
• Client Advocacy	$143,572	
• Emergency Financial Assistance	$76,532	
• Food Bank/Home-Delivered Meals/Nutritional Supplements	$115,053	
• Health Education/Risk Reduction	$4,444	
• Housing Services	$52,440	
• Housing-Related Services	$52,042	
• Mental Health Services	$118,129	
• Nutritional Counseling	$1,845	
• Oral Health	$73,710	
• Psychosocial Support Services	$20,890	
• Substance Abuse Services	$4,555	
• Transportation	$31,043	
• Treatment Adherence Services	$32,812	
• Other Support Services (Essential Needs Bank)	$19,557	
• Outreach	$3,890	

• Consortium Support	$112,234	
G. Construction -		**$0**
H. Other -		**$0**
I. TOTAL DIRECT CHARGES -		**$2,424,200**
J. Indirect –		**$31,515**
K. TOTAL Consortia		**$2,455,715**
6) Health Insurance		**$156,916**
A. Personnel –		**$0**
B. Fringe Benefits –		**$0**
C. Travel –		**$0**
D. Equipment -		**$0**
E. Supplies –		**$0**
F. Contractual –		**$154,902**
A portion of the Title II Base funding is set aside from consortia-related costs for the health insurance continuation program.		
G. Construction -		
H. Other –		**$0**
I. TOTAL DIRECT CHARGES -		**$154,902**
J. Indirect –		**$2,014**
K. TOTAL Health Insurance		**$156,916**
7) Minority AIDS Initiative		**$40,478**
A. Personnel –		**$0**
B. Fringe Benefits –		**$0**
C. Travel –		**$0**
D. Equipment -		**$0**
E. Supplies –		**$0**
F. Contractual –		**$39,959**
This money is contracted to a service provider in Pierce County to provide outreach and education to increase minority participation in ADAP and case management services.		
G. Construction -		**$0**
H. Other –		**$0**
I. TOTAL DIRECT CHARGES -		**$39,959**
J. Indirect –		**$519**
K. TOTAL Minority AIDS Initiative		**$40,478**

vi. Staffing Plan and Personnel Requirements

Please see Appendix B for an updated organizational chart for the Washington State Department of Health (DOH) and HIV Client Services, the administrative office for Title II funds including ADAP.

CHRISTINE O. GREGOIRE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 753-6780 • www.governor.wa.gov

December 1, 2005

The HRSA Grants Application Center
The Legin Group, Inc.
901 Russell Avenue, Suite 450
Gaithersburg, Maryland 20879

Dear Grants Management Specialist:

This letter confirms that the Washington State Department of Health (DOH) is our lead agency to complete an application for funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (Title II, HIV Care Grant).

The grant provides drugs and services to Washington State citizens affected by HIV and AIDS and DOH is responsible for carrying out the provisions of the grant. Currently, over 3,100 people are enrolled in our AIDS Drug Assistance Program.

The designated project director is Patty Hayes, DOH Assistant Secretary, Community and Family Health. She can be reached at (360) 236-3723.

Sincerely,

Christine O. Gregoire
Governor

cc: Patty Hayes, Department of Health

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.
PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET.
SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Patty Hayes	Assistant Secretary, Community and Family Health
APPLICANT ORGANIZATION	DATE SUBMITTED
Washington State Department of Health	1/03/06

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabil-itation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents
for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Patty Hayes	Assistant Secretary, Community and Family Health
APPLICANT ORGANIZATION	DATE SUBMITTED
Washington State Department of Health	1/03/06

Ryan White Comprehensive AIDS Resources Emergency Act of 1990, as Amended, Title II HIV CARE Grant Program

I, the Governor, or Authorized Designated Official, of the State or Territory of **Washington**, hereinafter referred to as "State," assure that:

B. 1. The public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes individuals with HIV disease, representatives from other CARE Act Title grantees, providers, public agency representatives, and if applicable, entities on Title I Planning Councils, in developing the comprehensive plan and commenting on the implementation of such plan;

B. 2. The public health agency that is administering the grant for the State will implement the Statewide Coordinated Statement of Need (SCSN) guidance defined by the Health Resources and Services Administration (HRSA) by selecting a process for development of the SCSN. The State will periodically convene a meeting of individuals with HIV disease, representatives of other Ryan White programs, providers, and public agency representatives to develop an SCSN, and will review and update the SCSN at least every three years.

B. 3. Furthermore, the State will:

B. 3. a. Provide for the establishment of a quality management program to assess the extent to which HIV health services provided to patients under this grant are consistent with the most recent Public Health Service guidelines for treatment of HIV disease and related opportunistic infections, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to, and quality of, HIV health services;

B. 3. b. Comply with the requirement that a minimum of Title II funds, not less than the percentage constituted by the ratio of the population of the State of women, infants, children, and youth with AIDS to the general population with AIDS (provided by the Division of Service Systems), will be used to provide health and support services to each population—women, infants, children, and youth with HIV disease —including treatment measures to prevent the perinatal transmission of HIV;

B. 3. c. To the maximum extent practicable, ensure that HIV-related health care and support services delivered pursuant to a program established with assistance provided under Title II will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual living with HIV;

B. 3. d. Ensure that such services will be provided in a setting that is accessible to low-income individuals living with HIV;

B. 3. e. Provide outreach to low-income individuals living with HIV to inform them of the services available under Title II;

B. 3. f. Ensure that the following conditions have been met in providing Early Intervention Services (EIS): Federal, State and local funds are otherwise inadequate for the EIS an entity proposes to provide and the entity will supplement, not supplant, other funds available to the entity for the purposes of providing EIS;

B. 3. g. Ensure that Consortia, in establishing their plan for services, consult with Title IV grantees or, if none are operating in the area, representatives of organizations with a history of serving children, youth, women, and families living with HIV;

B. 3. h. Ensure that Consortia demonstrate that adequate planning has occurred to meet the special needs of families living with HIV, including family-centered and youth-centered care;

B. 3. i. Comply with the requirement to take administrative or legislative action that a good faith effort will be made to notify a spouse of a known HIV-infected patient that such spouse may have been exposed to HIV and should seek testing; and

B. 3. j. If using amounts provided under the grant for health insurance coverage, the plan describes the State's program that assures that such amounts will be targeted to individuals who would not otherwise be able to afford health insurance coverage; that income, asset, and medical expense criteria will be established and applied by the State to identify those individuals who qualify for assistance under such a program; and that information concerning such criteria shall be made available to the public.

B. 4. The State will ensure that it complies with the limitations of grant funds for administration; planning and evaluation; and quality management activities. In the case of contractors (including Consortia), the State will ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10% (without regard to whether particular entities expend more than 10% for such expenses).

B. 5. The State will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under Title II.

B. 6. The State will permit and cooperate with any Federal investigations undertaken regarding programs conducted under Title II.

B. 7. The State will maintain HIV-related activities at a level that is equal to not less than the level of such expenditures by the State for the one-year period preceding the fiscal year for which the State is applying to receive a grant under Title II.

B. 8. The State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made, with respect to that item or service under any State compensation program, insurance policy, Federal or State health benefits program, or entity that provides health services on a prepaid basis.

B. 9. The State will ensure that entities receiving funds under this grant will maintain appropriate relationships with entities in the service area that constitute key points of access to the health care system for individuals with HIV disease (including emergency rooms, substance

abuse treatment programs, detoxification centers, adult and juvenile detention facilities, STD clinics, HIV counseling and testing sites, mental health programs, and homeless shelters) and other entities eligible to apply for Title III Early Intervention Service Grants for the purposes of facilitating early intervention for individuals newly diagnosed with HIV disease and/or individuals knowledgeable of their HIV status but not in care.

B. 10. The State will comply with the following requirements regarding imposition of charges for services, for those providers who charge for services:

B. 10. a. In the case of individuals with incomes less than or equal to 100% of FPL, the provider will not impose charges on any such individual for the provision of services under the grant;

B. 10. b. In the case of individuals with incomes greater than 100% of FPL, the provider will impose charges on such individuals for the provision of such services, and will ensure that a schedule of what constitutes permissible charges is made available to the public;

B. 10. c. In the case of individuals with incomes greater than 100% but not exceeding 200% of FPL, the provider will not, for any calendar year, impose charges in an amount exceeding 5% of the annual gross income of the individual involved;

B. 10. d. In the case of individuals with incomes greater than 200% but not exceeding 300% of FPL, the provider will not, for any calendar year , impose charges in an amount exceeding 7% of the annual gross income of the individual involved; and

B.10. e. In the case of individuals with incomes greater than 300% of FPL, the provider will not, for any calendar year, impose charges in an amount exceeding 10% of the annual gross income of the individual involved.

B. 11. Any State subject to the matching requirement detailed in Section 2617 (d) must make available, either directly or through donations from public or private entities, non-Federal contributions toward costs to be incurred by the State in carrying out the program(s) from which this grant was awarded.

B. 12. States and Territories applying for ADAP Supplemental Treatment Drug Grants will make available non-Federal contributions (directly or through donations from public or private entities) in an amount equal to $1 for each $4 of Federal funds awarded. In addition, States and Territories must assure that they have not changed their ADAP eligibility criteria to be more restrictive than that in place as of 01/01/00.

B. 13. States and Territories submitting a Notification of Intent to purchase health insurance, must assure cost neutrality in the aggregate and must assure a formulary comparable to the ADAP formulary.

B. 14. The State will ensure that 75% of Title II funds will be obligated within 120 days of the start date of the grant award.

B. 15. The State will ensure that no Title II funds will be expended to support needle-exchange programs.

Patty Hayes

Signature

Date: **1/03/06**

Assistant Secretary, Community and Family Health
Title
PO Box 47830, Olympia WA 98504-7830
Address

viii. Maintenance of Effort

DOH Title II staff consistently monitors the maintenance of effort through the following annual process:
1. Title II staff contacts the Washington State Office of Financial Management (OFM) to identify agencies with potential budget line items for HIV-specific activities.
2. Title staff contacts respective budget staff via email to confirm information gathered for the previous Title II application and to request documentation of General Funds State and/or local budget expenditures for any budget line item(s) with reference to HIV/AIDS. Agency budget staff uses the online financial budget and expenditure report to track expenditures.
3. Agencies provide written, faxed, or emailed confirmation of the data reported in the previous year's maintenance of effort table and new data for the State fiscal year immediately following.

The table and worksheet below document Maintenance of Effort for State Fiscal Years 2003 and 2004.

Maintenance of Effort Report

Item No.	Agency or Department	State FY 2003 Amount	State FY 2004 Amount
1.	Department of Health – Regional HIV/AIDS Networks	$7,778,663	$7,778,663
2.	Department of Health – Early Intervention Services – this includes ADAP and health insurance continuation.	$5,641,106	$6,669,213
3.	University of Washington – Support for HIV-related research and training	$224,204	$230,563
4.	Department of Health – Prevention and Education	$262,681	$293,068
5.	Department of Health – HIV Client Services Administration Costs	$38,240	$138,079
6.	Department of Health - HIV Case Management Administration – this includes administrative costs of the Statewide Case Management Coordinator.	$86,304	$78,686
7.	Department of Social and Health Services – HIV/AIDS Day Care Program	$572,967	$544,262
8.	Department of Health – Governor's Advisory Council on HIV/AIDS	$15,339	$16,803
	Total	**$14,619,504**	**$15,749,337**

Item 1 Agency/Department: Department of Health
Activity: AIDSNET-Regional Network for HIV/AIDS Services

State Fiscal Year 2003 amount: $7,778,663
State Fiscal Year 2004 amount: $7,778,663
Basis of amount: Actual expenses reported by the Department of Health's Accounting and Financial Reporting Data Distribution System and confirmed by Rebecca Pittman, Assessment/Infectious Disease and Reproductive Health Fiscal Manager.

Item 2 Agency/Department: Department of Health
Activity: Early Intervention Services – This includes ADAP, health insurance continuation, and spenddown

State Fiscal Year 2003 amount: $5,641,106
State Fiscal Year 2004 amount: $6,669,213
Basis of amount: Actual expenses reported by the Department of Health's Accounting and Financial Reporting Data Distribution System and confirmed by the Early Intervention Program's Fiscal and Contracts Specialist, Barb Stuart.

Item 3 Agency/Department: University of Washington
Activity: Clinical and laboratory facility- Rental costs on building, clinical lab space for treatment of patients with AIDS and the training of health care professionals

State Fiscal Year 2003 amount: $224,204
State Fiscal Year 2004 amount: $230,563
Basis of amount: Actual expenses reported by Lisa Billings, Department of Medicine Controller.

Item 4 Agency/Department: Department of Health
Activity: HIV/AIDS Education and Prevention

State Fiscal Year 2003 amount: $262,681
State Fiscal Year 2004 amount: $293,068
Basis of amount: Actual expenses reported by the Department of Health's Accounting and Financial Reporting Data Distribution System and confirmed by Rebecca Pittman, Assessment/Infectious Disease and Reproductive Health Fiscal Manager.

Item 5 Agency/Department: Department of Health
Activity: HIV Client Services Administrative Costs

State Fiscal Year 2003 amount: $38,240
State Fiscal Year 2004 amount: $138,079
Basis of amount: Actual expenses reported by the Department of Health's Accounting and Financial Reporting Data Distribution System and confirmed by the Early Intervention Program's Fiscal and Contracts Specialist, Barb Stuart.

Item 6 Agency/Department: Department of Health
Activity: HIV/AIDS Case Management Administration

State Fiscal Year 2003 amount: $86,304
State Fiscal Year 2004 amount: $78,686
Basis of amount: Actual expenses reported by the Department of Health's Accounting and Financial Reporting Data Distribution System and confirmed by the Early Intervention Program's Fiscal and Contracts Specialist, Barb Stuart

Item 7 Agency/Department: Department of Social and Health Services Aging and Disability Services Administration
Activity: HIV/AIDS Adult Day Care Program - Bailey Boushay House

State Fiscal Year 2003 amount: $572,967
State Fiscal Year 2004 amount: $544,262
Basis of amount: Actual expenses reported by Teri Comstock, Manager, Finance and Contracts, Aging and Disability Services Administration

Item 8 Agency/Department: Department of Health
Activity: Governor's Advisory Council on HIV/AIDS
State Fiscal Year 2003 amount: $15,339
State Fiscal Year 2004 amount: $16,803
Basis of amount: Actual expenses reported by the Department of Health's Accounting and Financial Reporting Data Distribution System and confirmed by Rebecca Pittman, Assessment/Infectious Disease and Reproductive Health Fiscal Manager

ix. Program Narrative

1. Grant Administration and Accountability

a. Program Organization

Title II funds are administered by the Department of Health's HIV Client Services section. This section operates within the Office of Infectious Disease and Reproductive Health (IDRH).

The Title II Administrator is responsible for writing and submitting the Title II grant application and overseeing consortia and case management-related activities. The HIV Client Services Program Manager coordinates the Early Intervention Program (EIP), Washington's AIDS Drug Assistance Program (ADAP). The EIP Eligibility Manager is responsible for the EIP daily operations and supervises three Client Services Representatives who enroll clients into EIP. The EIP Operations Manager supervises the program operations staff, works with computer programmers to maintain and update the EIP data system, and generates, analyzes and interprets data for program evaluation purposes. In addition, the IDRH Assessment Unit provides assistance with conducting quality assurance activities for Title II-funded services.

b. Fiscal and Program Monitoring

Fiscal monitoring is conducted in three ways:

1) A contracted certified public accountant (CPA) conducts fiscal monitoring site visits for each Title II-funded contractor once every two years unless there is reason to monitor annually. This monitoring is conducted in collaboration with several other DOH programs, minimizing disruption to contracted entities while providing consistent fiscal information to each contractor. Fiscal monitoring reports are received by Title II staff and reviewed for any significant issues discovered. Contractors are required to send corrective action plans to DOH staff identifying actions they intend to take to correct issues discovered by the CPA. In FY 2005, ten fiscal monitoring site visits were conducted.
2) Risk assessments are conducted on each Title II-funded contract to assist in determining the appropriate type and frequency of monitoring required.
3) Invoice vouchers are monitored carefully to ensure all costs being reimbursed are allowable. Contractors are contacted by email to clarify any questions and to provide documentation of questionable expenses.

Program monitoring is conducted in several ways:

1) Site visits are conducted at least once every two years with each Title II-funded contractor. Site visits allow time to tour the facilities, answer program-specific questions and concerns, and meet staff providing the services. Program-related issues arising from a site visit are addressed between DOH staff and the contractor immediately and until the issues are satisfactorily resolved. In FY 2005, eight program/consortia site visits were conducted.
2) Frequent contact with contractors via email and phone provide information on pressing issues.
3) Quarterly reports indicate the extent to which the contractor is meeting stated contract objectives, demographic information about clients served, and a brief narrative to address questions specific to the Title II semi-annual and annual progress reports.

Contractors are contractually obligated to conduct fiscal audits as required by their respective OMB circular. Once an audit is complete, it is sent to the Department of Health's grants management section for review. A letter is sent to the contractor and Title II staff acknowledging receipt of the audit and also identifying any issues of concern or follow up. One contractor is incompliant with the audit requirement. During the recent program site visit with this contractor, Title II staff were assured that every effort is being made to become current with their financial audit. The contractor will file for an extension with the Department of Health's grant management section.

There are no improper charges or other audit findings to note.

c. Third-Party Reimbursement

Title II staff ensures that contractors are monitoring for third-party reimbursement by including contract language requiring service providers to access third party payers prior to requesting Title II reimbursement. Specific contract language is:

The contractor assures that no Title II funds will be used to provide items or services for which payment has been made or reasonably can be expected to be made, by third party payers, including Medicaid, Medicare, and/or State or local entitlement programs, prepaid health plans or private insurance. Therefore, the contractor assures that eligible individuals will be expeditiously enrolled in Medicaid, and that CARE Act funds will not be used to pay for any Medicaid-covered services for Medicaid enrollees.

In addition, the Statewide Case Management Coordinator performs periodic site visits once every two years to all Title XIX-contracted case management providers to monitor compliance with Washington Administrative Code and confirm that Title II-funded case management providers are contracted with Medicaid.

The Early Intervention Program and the Evergreen Health Insurance Program (EHIP), the health insurance continuation program, screen clients to ensure that insurance premiums are not paid for clients who are Medicaid-eligible. EIP clients who are 100% of the Federal Poverty Level must apply for Medicaid and receive a written denial before eligibility is determined for ADAP or insurance premium assistance. EIP staff accesses Medicaid's Automated Client Eligibility System (ACES) to monitor for clients who may already have insurance or Medicaid spenddown at least annually.

Case management providers, Washington's largest Title II-funded service, use a comprehensive assessment screening tool to screen for third-party eligibility. One of the major categories included in the assessment tool is insurance which includes a comprehensive list of third-party payers. From information supplied on this tool, case managers are able to assist clients in obtaining the most appropriate services, ensuring that CARE Act funds are payer of last resort.

Title II-funded consortia-related providers maintain records for clients served with CARE Act funds to document client eligibility including HIV status, income, and residence. Consortia define low-income in their respective geographic areas to best meet the client-related needs.

2. Epidemiology

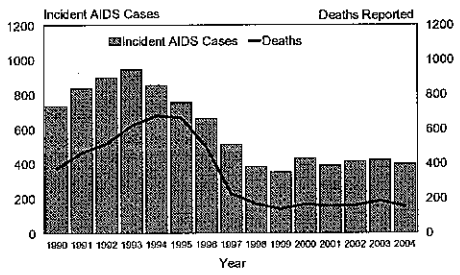
a. Washington State is using CDC-provided data for AIDS incidence and prevalence reported in Appendix A, Table 1. CDC-provided data are consistent with locally available data on AIDS incidence and AIDS prevalence from the Washington State HIV/AIDS Surveillance Program for the requested time period (1/1/03–12/31/04). Washington State HIV/AIDS Surveillance Program AIDS case reporting since 1994 has been determined to be ≥90 percent complete by 12 months following diagnosis. These data are used to characterize AIDS trends and are presented in Figures 1 and 2 below.

Information on HIV-related mortality is collected quarterly from the Washington State Center for Health Statistics and used to update the vital status of reported AIDS cases. Cases in the HIV/AIDS Reporting System (HARS) are also matched annually against the vital statistics database for the prior year to ensure that death reporting is complete for persons reported with AIDS, regardless of the underlying cause of death. Previous studies have shown death reporting

to be 15 percent, 34 percent, 56 percent, 70 percent, and 95 percent complete for AIDS cases at 3, 6, 9, 12, and 24 months respectively, after the date of death.

HIV prevalence among Washington State residents is based on HIV reporting. Washington State initiated name-based reporting of asymptomatic HIV infection in September 1999. These data are conservatively estimated to be 90% complete at 12 months following diagnosis as of December 2005. There were 3,852 HIV (non-AIDS) cases diagnosed and not known to be deceased as of December 2004 (reported through November 2005); adjusting for completeness of reporting, the total number of persons estimated to be diagnosed and living with HIV (non-AIDS) as of December 2004 is 4,280. This figure is reported in the third column of Table 1, Appendix A. This estimate of HIV-infected, non-AIDS diagnosed persons is consistent with earlier estimates and forecasts published in 1996 by the Washington State Department of Health in "HIV/AIDS Estimates and Forecasts: An Epidemiologic Report of Current Status and Projections through 1998." These estimates are also appropriate in light of those calculated for a recent study, "Evaluation of HIV Infection Reporting in Washington State: Year 1 Status Report, September 2000" and are also consistent with calculations of unmet need following HRSA guidelines for determining unmet need for HIV primary care.

Figure 1: AIDS Incidence & Deaths by Year*



*Cases and Deaths reported through 11/05

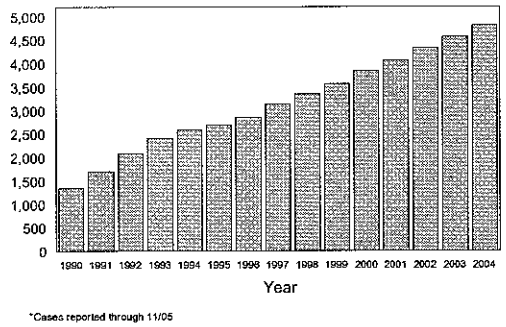
b. The first AIDS case in Washington State was diagnosed in 1982. Since that time, a total of 11,229 AIDS and 4,174 HIV cases have been reported among residents of Washington State (reported through November 2005). Data for cases reported through November of 2005 are used in this section to characterize recent trends and changes in HIV/AIDS in Washington State. The number of new AIDS cases diagnosed and deaths among AIDS cases in Washington State declined significantly between 1993 and 1999 (Figure 1). However, AIDS cases diagnosed in 2000 increased 21 percent over cases diagnosed the previous year. No significant upward or downward trend is evident since 2000 with an average of 400 cases being diagnosed per year. Significant annual decreases in mortality among persons with AIDS noted since 1995 appear also to have leveled off. These trends continue to suggest that the maximum population-level benefit of highly active antiretroviral therapy (HAART) has been realized.

Analyses of cases do not demonstrate significant differences in survival among AIDS cases of different racial/ethnic backgrounds, among persons in different risk categories or among individuals who resided in or outside King County at the time of their AIDS diagnosis.

The decline in AIDS-associated mortality noted since 1995 – largely attributed to an increase in the availability of HAART and more effective prophylactic treatments for opportunistic infections – combined with the increase in cases diagnosed since 2000, contributes to an increase in the number of persons living with AIDS (Figure 2). The number of persons living with AIDS increased 25.5% between 2000 and 2004. This increasing burden of disease among Washington

State residents poses significant challenges to the continuum of care. Recent analyses[1] of hospital discharge data indicate that HIV-related costs for in-patient care increased significantly from $20,000 per admission in 2000 to $30,000 in 2004, suggesting that some persons with HIV may be experiencing increased morbidity. The number of persons living with HIV (non-AIDS) has also increased significantly since HIV reporting began in 1999.

Figure 2: Persons Living with AIDS*



*Cases reported through 11/05

A gradual decline in the overall proportion of cases living with AIDS who are male is noted and is paralleled by slight declines in the proportion of PLWA whose infection was attributed to unprotected male-male sexual contact. In 1990, 88% of persons diagnosed with AIDS were men who have sex with men (MSM) or MSM and injection drug users (IDUs), whereas for cases diagnosed in 2005, 62% were MSM or MSM/IDUs. However, for HIV/non-AIDS cases diagnosed in 2005, the proportion of MSM or MSM/IDU exposure is 66%, indicating a potentially increasing trend toward a higher proportion of total infections attributable to MSM transmission risk.

The demographic characteristics of cumulative HIV and AIDS cases as compared to the characteristics of Washington State's 2004 population demonstrate that persons 20-44 years of age (all races) and non-Hispanic blacks have been disproportionately impacted by the epidemic. There is a recent trend toward an increased incidence of AIDS among the Hispanic community as well, which is reflected in a higher proportion of Hispanics among HIV cases relative to the cumulative AIDS total and to the state's 2004 population[2].

The changing demographic and risk behavior characteristics of HIV and AIDS cases are reflected in geographic shifts of cases from King County to other regions of Washington State. From 1990-1997, the proportion of Washington's AIDS cases diagnosed in Seattle-King County declined while the proportion of living AIDS cases resident outside Seattle-King County increased. In 2001, 56% of AIDS cases and 68% of HIV cases resided in King County at the time of their diagnosis. As of November 2005, 62% of AIDS cases and 66% of HIV cases were resident in King County at diagnoses.

3. Needs Assessment and Unmet Need

a. Needs Assessment

The 14 consortia throughout Washington now use a three-year planning process. In FY 2004, consortia identified topics where more information was needed in order to revise their priorities for FY 2005. Consortia then designed and implemented supplemental tools to update their needs assessment data for FY 2006 priority setting. These tools included focused provider surveys, client satisfaction surveys, and focus groups. Each consortium includes persons living with HIV

[1] Stenger, Mark; Rime, Todd; Washington State Dept. of Health, Unpublished, November 2005
[2] Washington State Population estimates, Office of Financial Management, April 2005

(PLWH) membership and is contractually obligated to maintain this standard. PLWH are included in all consortia-related processes.

Title II staff will implement a statewide needs assessment process to include consumer and provider surveys beginning in January 2006. These data will be compiled for consortia and then presented during regional prioritization and allocation meetings in April through August 2006. Consortia members will use this comprehensive needs assessment data to determine funding priorities for FY 2007.

Historically, there has been very little disparity between reported HIV/AIDS cases and those receiving care in Washington State. However, the statewide comprehensive needs assessment planned for 2006 will provide an updated look at the needs of HIV-positive individuals receiving care in Washington State.

Consortia report the following needs related to individuals with HIV and affected populations in historically underserved areas of the state:

- Maintaining an adequate continuum of care to keep HIV-positive individuals in their home communities. Rural consortia struggle to engage and retain both consumers and providers in the planning process.
- Adequate transitional and permanent housing. Housing resources are limited in rural areas and funding for programs such as Section 8 and HOPWA is decreasing.
- Adequate substance abuse and mental health treatment resources in rural areas. Available service providers are limited in rural areas, forcing consumers to travel to receive appropriate care.
- Transportation to access medical and support services. Several consortia span large geographic areas, making some form of transportation essential in receiving care services. Consortia are concerned that transportation will not be an allowable use of funds once reauthorization occurs.

b. Unmet Need

Introduction

In 2003 Washington State's Title II grantee and the Seattle EMA Title I grantee convened a cross-title collaborative work group to address the recently released Unmet Need Framework, developed by HRSA with technical assistance from UCSF. This work group was composed of Title I and Title II staff, HIV epidemiologists from Public Health – Seattle & King County and from DOH, as well as HIV surveillance and special project staff. The work group reviewed available data sources and discussed potential methods to respond to the Unmet Need Framework. The methods and data sources utilized for estimating the number/percentage of "HIV+ aware and not in care" represent the consensus decision of this collaborative work group and results presented below are for calendar year 2003. Additionally, preliminary results for calendar year 2004 are also presented; however, additional data sources and methods will be used before considering these estimates final for 2004.

Population Estimates

a)	Persons living with AIDS and aware of status as of 12/31/2003:	5,325
	Persons living with AIDS and aware of status as of 12/31/2004:	5,769
b)	PLWH (non-AIDS) aware of status as of 12/31/2003:	4,416
	PLWH (non-AIDS) aware of status as of 12/31/2004:	4,836

Denominator data for the Unmet Need Framework were calculated by adjusting HIV/AIDS surveillance data for estimated rates of completeness. Surveillance records were obtained for persons diagnosed with non-AIDS HIV or with AIDS and presumed to be living as of December 31st for each year of the analyses. These data were extracted from HARS, the statewide registry of HIV/AIDS cases maintained at DOH. Data for the analyses included all cases reported to HARS through August 2005, including those diagnosed elsewhere and known to be resident in Washington State. Based on conservative estimates of the completeness of reporting for non-AIDS HIV cases (85%) and for AIDS cases (95%) provided by surveillance staff, denominators for the unmet need analyses were calculated (Appendix A, Tables 2, 3, 14, and 15). For the purposes of these analyses, the diagnostic status of the case (AIDS or non-AIDS) was determined as of the end of the calendar year; persons progressing to AIDS within the previous 12 months were counted only once as an AIDS case for that particular year. Appendix A, Tables 3 and 15, provide denominators for overall calculation of the percentage and number of persons with an unmet need for HIV-primary care as defined by the Framework.

Estimates of People in Care

a)	PLWA aware of status as of 12/31/2003 and in care:	4,493
	PLWA aware of status as of 12/31/2004 and in care:	4,682
b)	PLWH (non-AIDS) aware of status and in care as of 12/31/2003:	3,171
	PLWH (non-AIDS) aware of status and in care as of 12/31/2004:	3,307

Care pattern data were obtained from the Laboratory Tracking Database (LTD) maintained at DOH. Washington State requires all public, private and commercial diagnostic laboratories to report patient-identified laboratory results for CD4+, HIV viral load and HIV indicator tests[3]. All detectable viral load tests and all CD4+ results less than 200 or 14% meet the reporting criteria and must be reported to public health authorities. These data are received and archived in LTD where they provide case-finding information and also provide evidence of disease progression. Surveillance staff estimates that 97% of eligible laboratory procedures performed for Washington State residents are captured through these reporting requirements.

While these laboratory data have the advantage of being unbiased with respect to source of funding for care (i.e., would include all HIV patients from CARE Act providers as well as Veteran's Administration (VA), Medicaid or private payer sources), the criteria for reporting excludes patients with CD4+ counts higher than 200 or undetectable viral loads and are therefore biased toward patients with more advanced HIV infection. To correct our data in the aggregate for those persons receiving only non-reportable laboratory results, we used the Adult Spectrum of Disease (ASD) study to establish what proportion of HIV/AIDS cases in a large sample of

[3] Washington Administrative Code (WAC)# 246-101, 201

patients from a diversity of clinical settings had only non-reportable laboratory procedures in 2003. The ASD study is a CDC-funded longitudinal medical record abstraction project designed to be representative of HIV-infected patients receiving care in multiple clinical settings; women and men of color were over sampled to insure adequate representation in the data set.

In 2003, medical records for 1,698 patients were abstracted from 9 clinics in the greater Seattle metropolitan area and one clinic in rural Washington. Of these patients, 1,390 had documentation of CD4+ or viral load testing for 2003. For 2003, the overall proportion of patients having only non-reportable laboratory results was 44.24% and, conversely, the proportion with reportable results was 55.76%. The distribution of a specific range of laboratory results in any large clinical population can reasonably be assumed to represent an intrinsic biometric measure for populations of persons with HIV disease. To adjust our care pattern data to correct for non-reportable results, this empirically determined proportion was obtained for a variety of sub-group strata by gender, race, and ethnicity. Correction factors were obtained for non-AIDS HIV patients as well as for those with a diagnosis of AIDS.

Estimates of Unmet Need

a)	Number of PLWA with Unmet Need, 2003 (Percent):	832 (15.6%)
	Number of PLWA with Unmet Need, 2004 (Percent):	1,087 (18.8%)
b)	Number of PLWH (non-AIDS) with Unmet Need, 2003 (Percent):	1,245 (28.2%)
	Number of PLWH (non-AIDS) with Unmet Need, 2004 (Percent):	1,529 (31.6%)

Data Sources

HIV/AIDS Reporting System (HARS)
WA State Laboratory Tracking System

Estimation Methods

Persons with matched laboratory data for 2003 (matched records from HARS and LTD) within the PLWH/A population were stratified in the same categories as the ASD data and adjusted to estimate the total number of patients 'in care' if all laboratory results were reportable. Appendix A, Tables 4 through 23, present detailed results of the specific calculations used to arrive at estimates of the number of persons in care for a variety of strata. The percentage of persons in care was obtained by dividing the number of persons found to be 'in care' in each stratum by the total population in that stratum. Estimates of the number and percentage of persons 'out of care' were similarly calculated. The Unmet Need Framework Table (corrected version provided by Mosaica, September 2005) for Washington State is included as Appendix A, Tables 2 and 3.

Consistent with the Unmet Need Framework, DOH employs a simplistic definition of HIV-specific primary medical care as evidenced by one or more CD4+ or Viral Load tests or evidence of antiretroviral therapy in a 12 month calendar year[4]. Care patterns were established using laboratory reporting data because these data are complete, readily available, are not biased with

[4] *Estimating Unmet Need for HIV-related Primary Medical Care: The Basics*; Mosaica Unmet Need TA Center of the TAC (pg 3)

respect to funding source, patient demographic characteristics or provider type, and are reliably de-duplicated by matching to the HIV surveillance case registry. The limitation of specific reporting criteria in the laboratory data is overcome using correction factors obtained empirically through a robust, long-standing medical record abstraction project. These are the most comprehensive and reliable data sources currently available to DOH for this purpose. However, it is acknowledged that considerable uncertainty accompanies these analyses; the sub-population data presented in Appendix A are shaded to reflect strata with lower confidence because of small N sizes used to calculate the ASD correction factor.

Assessment of Unmet Need

Data from Medicaid and VA, while currently available to DOH in aggregate, cannot reliably be de-duplicated and do not represent the full spectrum of persons in care; these data are biased toward low-to-moderate-income or military personnel. Additionally, Washington State laboratory reporting data do include reportable results for patients qualified for Medicaid as well as for those receiving care at VA facilities.

DOH plans to re-convene the Unmet Need work group to objectively re-examine these and other potential data sources and methods. Additionally, prescription drug services data from the AIDS Drug Assistance Program will be used in finalizing subsequent Unmet Need estimates. A strong advantage to adding ADAP data are that these data can be de-duplicated through matching with the HIV/AIDS case registry and will add evidence of antiretroviral therapy to the overall methodology. DOH also anticipates full implementation of the CDC-sponsored Medical Monitoring Project (MMP) in Washington State to replace the laboratory reporting adjustments using the ASD study, which ended in 2004. DOH has also begun internal discussions to revise laboratory reporting requirements to include all CD4+ and viral load testing – regardless of result. These changes will result in more robust data sources for future estimates of unmet HIV-related primary medical care needs.

Women and blacks represent the sub-populations with highest unmet need from our analysis in both 2003 and 2004. DOH is participating in a CDC-sponsored project to identify and contact persons not initiating medical care (using the same criteria of CD4+ and Viral Load testing as evidence of care) to investigate intrinsic and extrinsic barriers to accessing care. These interviews will include an intervention referring those found not to be currently accessing care to appropriate providers of HIV-specific primary care. This project, know as the Not-In-Care supplement to the MMP project, is a collaborative between Public Health – Seattle & King County (the Seattle EMA Title I grantee) and the Title II grantee.

4. Quality Management

a. Description of Quality Management Program

Quality Management is viewed by DOH as a critically important team activity. The team for quality management is comprised of the Title II Administrator, HIV Client Services Program Manager, EIP Eligibility Manager, EIP Operations Manager, and the Statewide Case Management Coordinator. Team members meet regularly to coordinate ongoing implementation

of an overarching quality management plan and to monitor progress toward meeting specific quality management outcome goals.

Beginning in 2000, HIV Client Services and the Department of Health's Assessment Unit have been working with consortia, regional AIDSNET coordinators, and the Title XIX case management staff to develop and implement a client-centered quality management program. System Acuity Measurement (SAM) grew out of this collaborative and is contractually required of all Title II-funded case management providers.

SAM provides outcome-based measures of the impact individual clients have on the overall case management system in all essential supportive service areas and provides a common set of measures to describe the client-level burden for case management activities throughout the State. Client-level measurement can be aggregated to provide data at the agency, consortia, regional and state levels.

SAM data are collected from all case management agencies as part of the consortia quarterly reports. These data were recently analyzed and presented to case managers and agency staff at a statewide HIV/HCV conference in November 2005. Outcome measures available through SAM are directly applicable to quality management efforts and include longitudinal data on average client acuity, staff-to-client ratios and monthly caseload measurement at the case manager, agency, consortia and state levels. These data are useful in determining equitable distribution of case management resources between agencies and consortia and in identifying sudden or unexpected changes in case management burden across the care continuum.

The Case Management Planning and Evaluation Group (CMPEG) was formed in November 2004 to begin addressing HIV case management quality management and evaluation issues on a statewide level. The purpose of the CMPEG is to objectively review, evaluate, and make recommendations for improving HIV case management. The development of uniform case management service standards is the first major task of the CMPEG as part of an overall, long-term case management vision and plan. CMPEG membership consists of twelve HIV case managers representing each AIDSNET Region in Washington State. Membership also includes the Title I Administrator for the Seattle EMA to insure true statewide representation.

Another essential component of the quality management plan is periodic site visits to agencies contracted to provide Title II-funded services. Site visits are conducted at least once every two years using a comprehensive standardized assessment to measure compliance with existing service standards. Title II agencies are assessed for case management supervision, caseload numbers, case manager qualifications, continuing education and training of staff, and System Acuity Measurement compliance. All case management-related forms are reviewed in the course of a comprehensive client chart audit and technical assistance is provided where necessary to ensure the highest level of compliance.

ADAP Quality Management

DOH has an internal work group consisting of the Title II Administrator, HIV Client Services Program Manager, EIP Eligibility Manager, EIP Operations Manager and Assessment Unit staff

who met in FY 2004 to assess the ADAP quality management program. The collaborative nature of the work group assures there is coordination between Title II and ADAP staff on a regular basis.

This work group created a logic model to provide overall context and a timeline for current and future quality management efforts. This logic model provided an ongoing framework to help identify program areas where quality management efforts are needed, identify available resources for quality management and locate data that are needed to monitor efforts into the future. An early, tangible result of this work group's effort has been the development of an ad hoc evaluation committee. This committee includes members of the Early Intervention Program Steering Committee. The committee evaluated two current cost-saving mechanisms: mandatory Medicaid referral and cost share. The evaluation found that 42% of contracted pharmacies reported having observed clients going without medications because of an inability to pay the cost-share amount. When compared to 53% reporting clients going without needed medications in FY 2003, the evaluation identified a clear improvement in the medication distribution system as a result of changes implemented.

The ADAP program is collaborating with the Department of Health's Assessment Unit on the CDC-funded medical monitoring project. The project collects comprehensive information from clients and from their medical records. Clients are identified for the study from a representative sample of medical providers (2 stage, stratified sample). Most of these providers serve EIP clients, which will allow the project to evaluate client demographics, provider characteristics, analyze trends in health care utilization and fully characterize compliance with U.S. Public Health Service Guidelines for the treatment of persons with HIV disease, a key evaluation goal of Washington State's Title II program.

EIP staff, along with our contracted Pharmacy Benefits Manager (PBM) Ramsell, Inc., also collaborate to monitor the following ADAP indicators:

- Prior authorization turn-around time,
- Number of grievances concerning prior authorizations,
- Client utilization data,
- Geographic adequacy of pharmacy network,
- Quarterly updates of charts to review utilization, expenditures and demographic patterns including comparison of costs for insured versus uninsured clients, and
- Appropriate dispensation of certain medications requiring prior authorization.

The EIP Steering Committee serves as the planning/advisory body for EIP and will continue in this capacity to assist with ongoing evaluation activities and identifying needed program changes to improve quality and manage costs. The information learned from all ADAP quality management activities is analyzed by the DOH internal work group and shared with the EIP Steering Committee to use in enhancing current and future quality management efforts.

5. Consistency with the Statewide Coordinated Statement of Need (SCSN)

- The draft SCSN identified four cross-cutting themes:
    - Providing a dynamic, client-centered continuum of HIV care,

- Changing demographics of HIV populations,
- Linking prevention and care, and
- Changing social and political landscape.

The proposed 2006 allocations reflect the changing needs of the HIV populations and help to assure a client-centered continuum of care throughout the state.

- The four cross-cutting themes from the SCSN are being use to develop the framework for the revised comprehensive plan. Services being provided under Title II will be described using these themes.

6. The Public Advisory Planning Process

The Title II comprehensive plan is being revised by the Department of Health's Title II staff. The revised plan will be reviewed, finalized, and implemented in coordination with Washington's 14 Title II consortia, six AIDSNET Regional Coordinators, and other CARE Act grantees. The six AIDSNET Regional Coordinators represent an established regional system of planning, oversight, information, and resource distribution for HIV prevention and care services known as Regional AIDS Networks or AIDSNETS, created by the AIDS Omnibus law.

During January 2006, the revised comprehensive plan will be distributed among all consortia, the six AIDSNET Regional Coordinators and other CARE Act grantees. A conference call will be scheduled during the last two weeks of January to hear comments from these individuals and to answer questions regarding the plan.

7. Implementation Plan

a. Table: FY 2006 Implementation Plan

Appendix A, Table 24, provides detail about how Title II funds will be used in FY 2006 for Consortia, Health Insurance Continuation, ADAP, and the Minority AIDS Initiative. The Table provides estimates of the amount of funds to be allocated, the number of clients to be served, and the number of service units to be provided.

b. Narrative:

- The six essential core services are funded consistently with the needs identified by each consortium. Overall, consortia plan to allocate 72% of their funding to the essential core services. Consortia continue to identify Ambulatory/Outpatient (primary medical care) and ADAP as high ranking priorities, but allocate little to no funding to these services because Washington has very comprehensive ADAP, health insurance, and Medicaid programs.

  Each consortium provided a narrative justification to the Title II program staff to describe if core services are being fully funded and if not, how those services are being met within their respective regions.

- Consortia report in their annual application the amount of funds expended on women, infants, children, and youth (WICY) for the last fiscal year and expected expenditures for the

upcoming fiscal year. In addition, the annual WICY report submitted by DOH documents that expenditures are consistent with Washington state's WICY population.

- DOH chose to focus the Minority AIDS Initiative (MAI) funding in Pierce County. The first phase of the project began with Pierce County service agencies or practitioners and provided education about HIV-related services to increase the number of African Americans participating in the AIDS Drug Assistance Program and case management services.

  With replenished MAI funding for FY 2006, Action Association Counseling Services will continue the work of the project and will provide outreach to HIV-infected African Americans in Pierce County who are not currently enrolled in the AIDS Drug Assistance Program or receiving HIV care services. Staff at Action Association also facilitates a monthly provider work group for Pierce County minority service providers to enhance collaborative efforts in providing services to HIV-positive African Americans. Specific goals of the project include:

  - Engaging HIV-positive African Americans not currently enrolled in ADAP or HIV care services.
  - Conducting presentations targeted to community providers serving the African American community in Pierce County to provide information about available HIV care services and how to access those services.

  Enrollment in ADAP will be monitored in FY 2005 for increased enrollment of HIV-positive African Americans residing in Pierce County.

- Consortia-related services are consistent with Objective 13-14, 13-15, and 13-16 of the Healthy People 2010 initiative by providing ancillary care services to help infected individuals obtain and maintain appropriate medical care to reduce the threat of death and extend the interval of time between HIV diagnosis and death.
- The Early Intervention Program is consistent with Objective 13-13 and 13-14 by ensuring access to a comprehensive HIV formulary and therefore reducing overall deaths from HIV infection.
- The Minority AIDS Initiative is consistent with Objective 13-7 by helping African Americans in Pierce County learn about their HIV status and obtain medical and supportive care.

FY 2006 AIDS Drug Assistance Program (ADAP) Application

1. Program Description

ADAP Funding Resources

ADAP funds are a combination of Title I and Title II funds and state funds. These funds pay for prescription drugs and insurance premiums that cover prescription drugs. Drug rebates received through the 340B program are also used to pay for drugs. There are no anticipated funding shortfalls for FY 2006.

Client Utilization of ADAP Services

a. Figure 3 compares ADAP enrollee demographics to living HIV and AIDS cases as of December 2005. ADAP client trends indicate that 58% of ADAP clients enrolled in FY 05 were non-Hispanic White compared to 71% of presumed living HIV and AIDS during the same time period. ADAP client enrollment is somewhat different from living HIV/AIDS cases with respect to the proportion identified as Black, American Indian/Alaska Native, Native Hawaiian /Other Pacific Islander or other race. Race is more completely ascertained for reported HIV/AIDS cases versus enrolled ADAP clients, with 9 percent of ADAP enrollment not specifying race. With respect to gender, ADAP client enrollment is comparable to living HIV/AIDS cases.

Figure 3. Demographic Comparison of ADAP Clients to HIV/AIDS Cases*

Category	ADAP Enrollment 04/01/05-12/22/05		HIV+AIDS Cases* Living as of 11/30/05	
Race/ethnicity	**Number**	**%**	**Number**	**%**
White-not hispanic	1970	58.34%	7538	71.3%
Black-not hispanic	400	11.84%	1500	14.2%
Hispanic	440	13.03%	993	9.4%
Nat Hawaiin/PI	20	0.59%	22	0.2%
Asian	56	1.66%	223	2.1%
American In/Al Native	54	1.60%	188	1.8%
Multi-race	130	3.85%	43	0.4%
Not specified/other	307	9.09%	60	0.6%
Tot.	3377	100.0%	10567	100.0%
Gender	**Number**	**%**	**Number**	**%**
Male	2969	87.92%	9198	87.0%
Female	404	11.96%	1369	13.0%
Unknown/other	4	0.12%	0	0.0%
Tot.	3377	100.00%	10567	100.0%

* HIV/AIDS cases reported and not known to be deceased as of 11/30/2005.
Includes cases diagnosed elsewhere and known to be receiving care in Washington State

Significant differences between ADAP enrollment and reported, living HIV/AIDS cases, most notably in the proportion of clients identified as non-Hispanic White race, may be explained by several factors: ADAP client enrollment identifies more persons in a multiple race category (3.8% vs. 0.4%) and as unknown/other (9% vs. 06%) than the HIV/AIDS Reporting System. Misclassification in the ADAP client data system may account for some of the identified disparity. Additionally, 2000 census data for Washington State indicates significant disparity in socio-economic status between whites and blacks. Whites are more likely to have greater access to additional resources and alternate methods of covering costs for HIV-related medications (i.e., private insurance). This disparity is reflected in ADAP enrollment, consistent with policies reserving ADAP as the funding source of last resort for HIV-related medications.

b. In October 2002, the EIP implemented client cost sharing in response to Washington State legislative requirements. The cost sharing program requires some clients, based on income, to share in the costs of their medication. The initial program implementation required cost

sharing for uninsured clients with incomes above 125% of the federal poverty level. In April 2004, the EIP expanded cost sharing to include some insured clients and increased the amount of cost sharing for others. These changes were in response to a legislative requirement to increase savings from cost sharing.

No new program access restrictions were implemented during FY 2005 to any clients.

c. Total annual EIP enrollment grew 2.6% from 3,290 in FY 2004 to 3,377 in FY 2005, while utilization of prescription drugs decreased approximately 1% from 2,033 in FY 2004 to 1,955 in FY 2005. Increased growth from FY 2003 to FY 2004 was due to the transfer of the Evergreen Health Insurance Program from the Department of Social and Health Services to DOH.

ADAP Cost-Saving Strategies

Rebate Option

a. DOH continues to contract with Ramsell, Inc. to process client pharmacy claims. Ramsell contracts with a large network of private and Public Health Service pharmacies throughout Washington. Clients also have access to mail-order prescription services. Ramsell regularly attends the EIP Steering Committee meetings, providing expertise and consultation to the committee as a whole and to the formulary subcommittee. As of December 22, 2005, Ramsell has 856 active and 35 inactive pharmacies in their network.

b. DOH and Ramsell negotiate the reimbursement rate pharmacies receive and a dispensing fee. These rates have remained the same since 2002. The drug reimbursement rates are based on Average Wholesale Price (AWP). Presently the rates are AWP minus:

- 13.5% for brand products purchased from private pharmacies;
- 36.0% for brand products purchased from PHS pharmacies;
- 35.0% for generic products purchased from private pharmacies; and
- 46.0% for generic products purchased from PHS pharmacies.

The processing fee is $5.00 for antiretroviral drugs and $3.00 for non-antiretrovirals. DOH also pays Ramsell a $5.25 per claim processing fee. This fee pays for Ramsell's coordination of benefits service.

c. Rebate funds are received by DOH's, Office of Revenue and are uniquely coded within the accounting system to monitor the receipt and use. These funds are only used to purchase additional pharmaceuticals.

ADAP Linkages

a. To ensure that ADAP is the payer of last resort, EIP coordinates with third-party payers in the following ways:

- EIP requires all clients at or under 100% of the Federal Poverty Level to apply for Medicaid before being granted full EIP eligibility. Although this has helped contain EIP costs, EIP will

evaluate the cost-effectiveness of this requirement for Medicare recipients given the new Medicare Part D Prescription Drug Plan.

- Consistent with HRSA/HAB Policy Notice 04-01, eligible EIP clients were contacted to ensure they were aware of health care resources available to them through the Veteran's Administration and how those benefits could be coordinated with EIP coverage.

- EIP staff worked closely with the Center for Medicare and Medicaid Services (CMS) to coordinate services for Medicare Part D Prescription Drug Plan clients. In addition, EHIP will pay for Medicare Part D Prescription Drug Plans for clients who are not eligible for Social Security's low income subsidy.

- Ramsell maintains working relationships with secondary payers to coordinate benefits for EIP clients and, therefore, assure ADAP is payer of last resort.

- EIP staff continue to access Medicaid's Automated Client Eligibility System to monitor for clients who may already have insurance or Medicaid spenddown.

- DOH maintains an interagency agreement with Medicaid to pay spenddown premiums for EIP-eligible clients. This provides comprehensive Medicaid coverage for these clients while reducing cost to ADAP.

b. In anticipation of the Medicare Modernization Act, HIV Client Services staff began meeting in 2004 to understand the potential impact on EIP. The expected impacts include a decrease in spenddown assistance, an increase in insurance premiums (Part D premiums), and a small to moderate increase in dual-eligible clients because some will now be eligible for Part D insurance wrap-around assistance through EIP.

DOH expects to serve 944 clients who are eligible for Medicare Part D during FY 2006. The anticipated costs are $1,396,805 for insurance premiums and drug copays.

c. Ramsell works closely with Title I- and Title III-funded clinics that have pharmacies to coordinate services across the state.

ADAP regularly reviews Title I and Title III clinic data on EIP clients. Title I clients are tracked monthly and the data is provided to the Title I Coordinator.

d. In Washington State, the majority of the clinical trials are performed through the University of Washington, AIDS Clinical Trial Unit (ACTU). DOH periodically mails information to newly enrolled ADAP clients as a way to increase knowledge about available clinical trials. In addition, the Statewide Case Management Coordinator and EIP Client Services Representatives send information via email to case managers regarding clinical trials and/or patient assistance programs as available.

3. ADAP Funded Health Insurance

The Evergreen Health Insurance Program administers the insurance continuation program for the Department of Health. EHIP provides premium payment assistance for eligible individuals living with HIV and AIDS.

a. EHIP staff informally research health insurance policies purchased through the program to ensure that formularies are as comprehensive as the current ADAP formulary. This provision will be included in future contract language.

To ensure cost effectiveness, EHIP conducts biennial evaluations (as per HRSA/HAB Policy Notice 99-01) on the cost effectiveness of purchasing insurance premiums versus paying for limited HIV care and HIV treatment. EHIP expects to complete this evaluation by January 14, 2006.

b. DOH anticipates using $2,276,387 of ADAP funds for health insurance in FY 2006. These funds purchase COBRA, Washington High Risk Insurance Pool (WSHIP) and private insurance plans. Starting in January 2006, EIP will also pay for Medicare Part D Prescription Drug coverage.

c. Insurance funds are identified by a line of coding. While this line of coding is also used to track medication costs, staff query the online accounting system by line of coding and vender number to track insurance payments. Claims-level data on premiums, copays and deductibles are maintained in a data base to meet ADAP quarterly reporting requirements.

No other programs in Washington State use ADAP funds to purchase health insurance.

d. The existing health insurance continuation program expects to serve 1000 clients in FY 2006.

e. The following policies were developed to guide the use of ADAP funds to cover Medicare Part D out-of-pocket costs for low-income beneficiaries in Washington:

- EIP will require that all Medicare clients enroll in a prescription drug plan (PDP). In addition, EIP will require that all Medicare clients with incomes <=150% FPL apply for the Low Income Subsidy (LIS) offered through the Social Security Administration.

- EIP will pay PDP premiums and will offer to pay copays or a percentage of drug costs (co-insurance) for EIP formulary medications for program participants enrolled in a PDP (or a Medicare Advantage plan that includes prescription coverage).

- EIP will continue to pay insurance premiums for Medicare clients who have creditable insurance if their income is >=135% FPL or they do not qualify for LIS. EIP will no longer pay insurance premiums for Medicare clients with incomes <135% FPL or who qualify for LIS.

- EIP will continue to assist Medicare clients to meet their Medicaid spenddown if their incomes are >=135% FPL or they do not qualify for LIS. Once their spenddown is met, these clients will be considered dual eligibles for the remainder of the calendar year. EIP will no longer assist Medicare clients to meet their Medicaid spenddown if their incomes are <135% FPL.

EIP will enter into a data sharing agreement with CMS to facilitate coordination of benefits and list EIP as a supplemental payer of drug coverage for clients enrolled in Medicare drug plans. The agreement allows for accurate tracking of true out-of-pocket costs which benefit EIP Medicare beneficiaries.

f. EHIP uses WSHIP to purchase policies for clients. Clients must be refused by another insurance company in order to access WSHIP coverage. Currently, there is a cap on enrollment for people living with AIDS. There is not a cap for those living with HIV.

EHIP pays COBRA private insurance premiums for clients whose policies meet the criteria for cost-effective coverage as stated in paragraph a. above.

Appendix A – Tables

Table 1: AIDS Incidence, AIDS Prevalence and HIV (not AIDS) Prevalence by Demographic Group and Exposure Category as of 12/2003.

Demographic Group/ Exposure Category	AIDS Incidence: 01/01/03 to 12/31/04 (See note 1)		AIDS Prevalence as of 12/31/04 (See note 1)		HIV (not AIDS) Prevalence as of 12/31/04 (See note 2)	
	AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified.		*AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.*		*HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.*	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	622	65.4%	3,682	71.7%	3078	71.9%
Black, not Hispanic	154	16.2%	701	13.6%	632	14.7%
Hispanic	113	11.9%	516	10.1%	337	7.9%
Asian/Pacific Islander	30	3.1%	114	2.2%	117	2.8%
American Indian/Alaska Native	22	2.3%	102	2.0%	66	1.6%
Multi- Race	9	0.9%	12	0.23%	15	0.3%
Unknown	1	0.02%	10	0.18%	31	0.8%
Total	951	100.00%	5,137	100.00 %	4280	100.00%
Gender	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male	795	83.6%	4,511	88.19%	3663	85.6%
Female	156	16.4%	626	11.81%	616	14.4%
Total	951	100.00%	5,137	100.00 %	4280	100.0%
Age at Diagnosis (Years)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
<13 years	2	0%	6	0.12%	41	1.0%
13 - 19 years	1	0.09%	8	0.15%	114	2.7%
20 - 44 years	655	73.95%	2,791	54.3%	3673	85.8%
45+ years	293	25.95%	2,332	45.4%	451	10.5%
Total	951	100.00%	5,137	100.00 %	4280	100.0%

Appendix A – Tables, continued

Table 1 (continued): AIDS Incidence, AIDS Prevalence and HIV (not AIDS) Prevalence by Demographic Group and Exposure Category as of 12/2003.

Demographic Group/ Exposure Category	AIDS Incidence: 01/01/02 to 12/31/03 (See note 1)		AIDS Prevalence as of 12/31/03 (See note 1)		HIV (not AIDS) Prevalence as of 12/31/03 (See note 2)	
	AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified.		*AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.*		*HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.*	
Adult/Adolescent AIDS Exposure Category	#	% of Total	#	% of Total	#	% of Total
Men who have sex with men	569	59.8%	3,324	64.7%	2713	63.4%
Injection drug users	125	13.1%	579	11.3%	383	8.9%
Men who have sex with men and inject drugs	79	8.3%	500	9.7%	344	8.0%
Heterosexuals	165	17.4%	641	12.5%	436	10.2%
Other/Hemophilia/ blood transfusion	9	0.9%	64	1.2%	26	0.6%
Risk not reported or identified	4	0.4%	15	0.29%	337	7.9%
SubTotal	951	100.00%	5,123	99.7%	4242	99.1%
Pediatric AIDS Exposure Categories	#	% of Total	#	% of Total	#	% of Total
Mother with/at risk for HIV infection	0	0	12	0.23%	37	0.9%
Other/Hemophilia/ blood transfusion	0	0	2	0.03%	0	0
Risk not reported or identified	0	0	0	0%	0	0
Total	951	100.00%	5,137	100.00 %	4280	100.00%

Appendix A – Tables, continued

Table 2: Unmet Need Framework Table, Title II, Washington State, 2003

Unmet Need Framework Table, Title II, Washington State Calendar Year 2003				
Column 1	Column 2	Column 3	Column 4	Column 5
Population Sizes		**Value**		**Data Source(s)**
Row A.	Number of persons presumed living with AIDS (PLWA) and aware of status, as of 12/31/2004	5,325		HARS (HIV AIDS Reporting System) case registry, Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. HARS data are conservatively adjusted for estimated completeness of reporting (95% for AIDS, 85% for Non-AIDS HIV).
Row B.	Number of persons presumed living with HIV (PLWH)/non-AIDS/aware, as of 12/31/2004	4,416		HARS (HIV AIDS Reporting System) case registry, Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. HARS data are conservatively adjusted for estimated completeness of reporting (95% for AIDS, 85% for Non-AIDS HIV).
Care Patterns		**Value**		**Data Source(s)**
Row C.	Number of PLWA who received the specified HIV primary medical care services [as evidenced by laboratory results (CD4+ or Viral Load) between 01/01/2004 and 12/31/2004	4,493		Laboratory Tracking Database, (LTD), Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. LTD is a repository of all legally reportable HIV-related laboratory results. Revised Code of Washington (RCW) requires reporting of CD4+ results <200 or <14% of total lymphocytes, detectable HIV viral load results and all HIV-specific indicator tests. These data are required to be reported by all public and commercial diagnostic laboratories without regard to funding source or patient characteristics, are considered comprehensive for all patients/clinicians seeking HIV-specific laboratory services in Washington State. The data have been estimated at 97% compete for eligible lab results. Care patterns are established by matching unique individuals in LTD with HARS surveillance registry. Resulting care patterns are adjusted to correct for laboratory results outside of the threshold criteria for reporting by utilizing population-specific correction factors empirically determined from the Adult Spectrum of Disease (ASD) study data (see narrative).
Row D.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care services [as evidenced by laboratory results (CD4+ or Viral Load) between 01/01/2004 and 12/31/2004	3,171		See discussion above.
Calculated Results		**Value**	**Percent**	**Calculation**
Row E.	Number of PLWA who did not receive primary medical services	832	16%	Row A - Row C, Percent Value: (Row E/Row A)*100
Row F.	Number of PLWH/non-AIDS/aware who did not receive primary medical services	1,245	28%	Row B - Row F, Percent Value: (Row F/Row B)*100
Row G.	Total HIV+/aware not receiving specified primary medical care services (quantified estimate of unmet need)	2,077	21%	(Row A + Row B) - (Row F + Row E) , Percent Value: ((Row F + Row E)/(Row A + Row B))*100

Appendix A – Tables, continued

Table 3: Preliminary * Unmet Need Framework Table, Title II, Washington State, 2004

Preliminary* Unmet Need Framework Table, Title II, Washington State Calendar Year 2004				
Column 1	Column 2	Column 3	Column 4	Column 5
	Population Sizes	**Value**		**Data Source(s)**
Row A.	Number of persons presumed living with AIDS (PLWA) and aware of status, as of 12/31/2004	5,769		HARS (HIV AIDS Reporting System) case registry, Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. HARS data are conservatively adjusted for estimated completeness of reporting (95% for AIDS, 85% for Non-AIDS HIV).
Row B.	Number of persons presumed living with HIV (PLWH)/non-AIDS/aware, as of 12/31/2004	4,836		HARS (HIV AIDS Reporting System) case registry, Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. HARS data are conservatively adjusted for estimated completeness of reporting (95% for AIDS, 85% for Non-AIDS HIV).
	Care Patterns	**Value**		**Data Source(s)**
Row C.	Number of PLWA who received the specified HIV primary medical care services [as evidenced by laboratory results (CD4+ or Viral Load) between 01/01/2004 and 12/31/2004	4,682		Laboratory Tracking Database, (LTD), Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. LTD is a repository of all legally reportable HIV-related laboratory results. Revised Code of Washington (RCW) requires reporting of CD4+ results <200 or <14% of total lymphocytes, detectable HIV viral load results and all HIV-specific indicator tests. These data are required to be reported by all public and commercial diagnostic laboratories without regard to funding source or patient characteristics, are considered comprehensive for all patients/clinicians seeking HIV-specific laboratory services in Washington State. The data have been estimated at 97% compete for eligible lab results. Care patterns are established by matching unique individuals in LTD with HARS surveillance registry. Resulting care patterns are adjusted to correct for laboratory results outside of the threshold criteria for reporting by utilizing population-specific correction factors empirically determined from the Adult Spectrum of Disease (ASD) study data (see narrative).
Row D.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care services [as evidenced by laboratory results (CD4+ or Viral Load) between 01/01/2004 and 12/31/2004	3,307		See discussion above.
	Calculated Results	**Value**	**Percent**	**Calculation**
Row E.	Number of PLWA who did not receive primary medical services	1,087	19%	Row A - Row C, Percent Value: (Row E/Row A)*100
Row F.	Number of PLWH/non-AIDS/aware who did not receive primary medical services	1,529	32%	Row B - Row F, Percent Value: (Row F/Row B)*100
Row G.	Total HIV+/aware not receiving specified primary medical care services (quantified estimate of unmet need)	2,616	25%	(Row A + Row B) - (Row F + Row E) , Percent Value: ((Row F + Row E)/(Row A + Row B))*100

* 2004 estimates are preliminary, based on 2003 ASD adjustments.

Detailed Unmet Need Framework for sub-group populations, Washington State Title II (Tables 4 through 13), 2003

Table 4
Raw Data From HIV/AIDS Reporting System (HARS)
Population Denominators: Reported Cases,
Not Known to be Deceased as of 12/31/2003
HARS data for cases reported through 8/2005

Group	HIV	AIDS	Total
All	3754	5059	8813
Males	3214	4477	7691
Females	540	582	1122
White			
Total	2736	3661	6397
Males	2461	3358	5819
Females	275	303	578
Black			
Total	543	704	1247
Males	366	526	892
Females	177	178	355
Hispanic			
Total	291	491	782
Males	243	436	679
Females	48	55	103
All Other*			
Total	184	203	387
Males	144	157	301
Females	40	46	86

Table 5
Estimated Total Population
Adjusted for Reporting Completeness
(95% for AIDS, 85% for HIV)

Group	HIV	AIDS	Total
All	4416	5325	9741
Males	3781	4712	8493
Females	635	612	1247
White			
Total	3218	3853	7071
Males	2895	3534	6429
Females	323	318	641
Black			
Total	638	741	1379
Males	430	553	983
Females	208	187	395
Hispanic			
Total	342	516	858
Males	285	458	743
Females	56	57	113
All Other*			
Total	216	213	429
Males	169	165	334
Females	47	48	95

Table 6
Raw Lab Match
Actual Number with Lab Match in 2003
(Reported if CD4<200 or Viral Load Detectable)

Group	HIV	AIDS	Total
All	1673	2612	4285
Males	1425	2290	3715
Females	248	322	570
White			
Total	1231	1877	3108
Males	1109	1712	2821
Females	122	165	287
Black			
Total	247	379	626
Males	150	280	430
Females	97	99	196
Hispanic			
Total	103	241	344
Males	89	215	304
Females	14	26	40
All Other*			
Total	92	115	207
Males	77	83	112
Females	15	32	32

Table 7
ASD Findings*
Percent of total persons with at least one lab meeting reporting criteria in 2003
*Adult Spectrum of Disease Study

Group	HIV	AIDS	Total
All	52.8	58.1	55.8
Males	51.5	56.8	54.5
Females	58.9	66.7	62.8
White			
Total	53.2	56.6	55.1
Males	53.4	55.1	54.4
Females	51.3	70.6	62.2
Black			
Total	55.0	67.2	61.1
Males	50.0	64.6	57.5
Females	64.3	73.0	68.4
Hispanic			
Total	39.4	58.8	50.4
Males	34.8	60.3	50.4
Females	53.3	42.9	50.0
All Other*			
Total	66.7	50.0	57.4
Males	62.5	52.4	56.8
Females	72.7	46.2	58.3